JUNCTION SCHOOL DISTRICT PUPIL REGISTRATION **FOR OFFICE USE ONLY:** Stu. #:_____ Perm ID #:_____ GRADE:_____

LEGAL NAME: _____ BIRTHDATE: ___/___/___ SEX: M F NONBINARY GENDER_____
LAST FIRST MIDDLE

BIRTH CITY: _____ STATE: _____ COUNTRY: _____

PARENT/GUARDIAN: _____
NAME RELATIONSHIP PHONE-HOME/CELL PHONE-WORK EMPLOYER/OCCUPATION

STUDENT RESIDES WITH: Y / N E-MAIL ADDRESS: _____

PARENT/GUARDIAN: _____
NAME RELATIONSHIP PHONE-HOME/CELL PHONE-WORK EMPLOYER/OCCUPATION

STUDENT RESIDES WITH: Y / N E-MAIL ADDRESS: _____

PHYSICAL ADR: _____ MAILING ADR: _____
STREET CITY STATE ZIP STREET CITY STATE ZIP

DOES YOUR CHILD HAVE AN IEP OR 504 PLAN ☐ YES, IEP ☐ YES, 504 ☐ NO IEP OR 504 PLAN

PARENT EDUCATION LEVEL (PLEASE CHECK ONE): ☐ 1 = NOT A HIGH SCHOOL GRADUATE ☐ 2 = HIGH SCHOOL GRADUATE ☐ 3 = SOME COLLEGE
☐ 4 = COLLEGE GRADUATE ☐ 5 = GRADUATE SCHOOL/POST GRADUATE TRAINING

IS STUDENT HISPANIC OR LATINO? ☐ NO, NOT HISPANIC OR LATINO ☐ YES, HISPANIC OR LATINO

PLEASE CONTINUE TO ANSWER THE FOLLOWING BY CHECKING ONE OR MORE BOX TO INDICATE STUDENT'S RACE.

ETHNICITY: ☐ 1 = AMERICAN INDIAN/ALASKA NATIVE ☐ 2 = ASIAN INDIAN ☐ 3 = BLACK/AFRICAN AMERICAN ☐ 4 = WHITE ☐ 5 = CAMBODIAN
☐ 6 = CHINESE ☐ 7 = FILIPINO ☐ 8 = GUAMANIAN ☐ 9 = HAWAIIAN ☐ 10 = HMONG
☐ 11 = JAPANESE ☐ 12 = KOREAN ☐ 13 = LAOTIAN ☐ 14 = OTHER ASIAN ☐ 15 = OTHER PACIFIC ISLANDER
☐ 16 = SAMOAN ☐ 17 = TAHITIAN ☐ 18 = VIETNAMESE

HOME LANGUAGE: ☐ 00 = ENGLISH ☐ 01 = SPANISH ☐ 02 = VIETNAMESE ☐ 03 = CANTONESE ☐ 04 = KOREAN ☐ 05 = FILIPINO
☐ 09 = KHMER ☐ 10 = LAO ☐ 12 = ARMENIAN ☐ 23 = HMONG ☐ 29 = RUSSIAN ☐ 99 = OTHER

ENGLISH LANGUAGE FLUENCY: ☐ 1 = ENGLISH ONLY ☐ 2 = FLUENT ENGLISH PROFICIENT (FEP)
☐ 3 = REDESIGNATED FLUENT ENGLISH PROFICIENT (R-FEP) ☐ 4 = LIMITED ENGLISH PROFICIENT (LEP)

CHILDREN OF FAMILY							
NAME	BIRTHDATE	BOY	GIRL	NAME	BIRTHDATE	BOY	GIRL

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

As a legal custodian of _____, a minor, I hereby authorize the principal or his/her designee, into whose care the aforementioned minor pupil has been entrusted, to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to said minor upon the advice of any licensed physician and/or dentist.

It is understood that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary.

This authorization shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand that the Junction School District, it's employees, and its Board assume no liability of any nature in relation to the transportation or treatment of the said minor. I further understand that all costs of paramedic transportation, hospitalization, and any examination, X-Ray, or treatment provided in relation to this authorization shall be my responsibility.

***PLEASE NOTE:** Junction School District cannot give medication to your child without a Medication Release from signed by a doctor or parent. **Please contact the school office.**

SPECIAL INFORMATION: If your child has any of the following health problems, please check or state below:

☐ HEMOPHILIA	☐ ALLERGY	☐ ASTHMA	☐ SEIZURES	☐ HEAT
☐ CHRONIC DIZZINESS	☐ EMOTIONAL	☐ TUBERCULOSIS	☐ NOSE BLEEDS	☐ SENSITIVITY TO CERTAIN DRUGS

☐ OTHER:_____

PERMISSION FOR EMERGENCY CARE- Information as of (date)_____. If I cannot be reached at home or business, contact any of the following individuals:

1. Name:_____ Relationship to child: _____ Phone: (____) _____
2. Name:_____ Relationship to child: _____ Phone: (____) _____
3. Name:_____ Relationship to child: _____ Phone: (____) _____

In the event of any emergency, you have my permission to attempt to obtain treatment from: Dr._____ Phone: (____) _____ or any physician selected by the school who will provide emergency treatment.

It is understood that the named physician my refuse to provide emergency treatment without additional authorization from the parent or guardian.

PARENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

According to appropriate grade level schedules, all children will receive vision, hearing, and dental screening. You have the right to refuse these services for your child. Unless you notify the office in writing, your child will be screened at no expense to you. My 7th grade daughter/8th grade son may participate in the free scoliosis screening. Yes_____ No_____

I (we) the parent /guardian are active in the Armed Forces (Army, Navy, Air Force, Marine Corps, Coast Guard, or active duty or full-time Nation Guard). Yes_____ No _____

FOR SCHOOL USE ONLY- PLEASE DO NOT ENTER INFORMATION BELOW

DISTRICT MOBILITY:_____ SCHOOL MOBILITY:_____ SPED SERVICES:_____ GATE:_____ NSLP:_____

DATE OF ENROLLMENT: ____/____/_____ GRADE:_____ LAST SCHOOL ATTENDED:_____

CUM REQUESTED:____/____/_____ CUM RECEIVED: ____/____/_____ CONF. FILE: Y N

Junction Elementary School District

Clay Ross/Superintendent
Shawn Martinez/Principal

9087 Deschutes Rd.
Palo Cedro, CA 96073
Phone: 530-547-3274
Fax: 530-547-4080
www.junctionesd.net

Board Members:
Hope Bjerke
Ishmael Rivas
Tom McConnel
Ken Parisot
Heather Richards

HOME LANGUAGE SURVEY

Directions to Parents and Guardians:
The *California Education Code* contains legal requirements which direct schools to determine the language(s) spoken in the home of each student. This information is essential in order for the school to provide adequate instructional programs and services.

As parents or guardians, your cooperation is requested in complying with this legal requirement. Please respond to each of the four questions listed below as accurately as possible. For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered.

1. Which language did your child learn when he/she first began to talk?_____

2. What language does your child most frequently speak at home?_____

3. What language do *you* (the guardian) most frequently use when speaking with your child?

   _____

4. Which language is most often spoken by adults in the home?_____

_____ _____
Signature of Parent/Guardian Date

_____ _____ _____
Name of Student Grade Age

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Student's Name:_____ Date:_____

Dear Parent/Guardian,

So we may better serve your child, please answer the following questions:

	YES	NO
1. My child was previously enrolled in a special program.	_____	_____
If known, what is the name of the program? _____		
2. My child was seeing a Speech Therapist	_____	_____
3. My child was in an Instrumental Music Program	_____	_____
4. My child needs to wear eyeglasses in school	_____	_____
5. My child can be released to either parent	_____	_____
If no, are custody papers on file in child's records?	_____	_____
6. My child has behavior problems in school	_____	_____
7. My child was in a GATE or MGM Program	_____	_____
8. My child has a hearing problem	_____	_____
9. My child has special needs	_____	_____
If yes, please indicate:_____		
10. Is English the primary language spoken in the home?	_____	_____
If the answer is no please explain:_____		

Parent/Guardian's Signature:_____

Comments:_____

_____

_____

_____

Junction Elementary School District

This document is intended to address the McKinney-Vento Assistance Act. Your truthful and accurate answers help the district identify services that the student may be eligible to receive.

Student:_____ (Male___ Female___)

Birthdate:____/____/____ Grade:_____

1. Do you and your student lived in a fixed, regular, adequate nighttime residence? ***Yes***___ ***No***___(If you circled "Yes," stop here. You may need to provide a utility bill in your name as proof of residence. *If you circled "No," please continue with this form.)*

2. Do you and the student live in:
   - □ shelter
   - □ motel/hotel
   - □ temporarily with another family in a house, mobile home, or apartment
   - □ in a car or RV
   - □ at a campsite
   - □ transitional housing
   - □ other location:_____
3. The student lives with:
   - □ one parent
   - □ two parents
   - □ a qualified relative
   - □ friend(s)
   - □ an adult that is not the legal guardian
   - □ alone with no adult(s)
4. I am:
   - □ the parent/legal guardian of the above-named student
   - □ a qualified adult relative of the above-named student (Relationship:_____)

I declare under penalty of perjury under the laws of this state that the information provided here is true and correct and of my own personal knowledge.

Signature:_____ Date:_____

Print Your Name:_____

Residence:_____
Street [p;''City Zip

Mailing Address:_____
Street City Zip

Telephone: (____)_____ Cell Phone: (____)_____

****

For School Use Only **Date Received:** ____/____/____

_____ Student not covered by McKinney Vento Act
_____ Student covered by McKinney-Vento Act
_____ Follow-up required

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Heather Richards

TO:_____ FROM: _____

FAX:_____ PAGES: _____

PHONE:_____ DATE: _____

REQUEST FOR RECORDS

The following students have enrolled in our school. Please send the cumulative and confidential records, including psychological, health, speech, and all Special Education materials.

Last Name	First	M.I.	Birthdate
Last Name	First	M.I.	Birthdate
Last Name	First	M.I.	Birthdate

Mail To: Junction Elementary School District
9087 Deschutes Rd.
Palo Cedro, CA 96073

Sincerely,

Elizabeth Paris
Administrative Secretary

Junction Elementary School District

Clay Ross/Superintendent
Shawn Martinez/Principal

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TRANSPORTATION INFORMATION

Child's Name:_____ Grade:_____

First Name or Nickname Child answers to:_____

Parent/Guardian Name:_____

Home Address:_____
Street City State Zip

Primary Phone Number:_____ Secondary Phone Number:_____

Address your child will be going to after school:

_____
Street City State Zip

Please draw a map showing the nearest crossroads:

_____ _____
Signature of Parent/Guardian Date

NOTE: It is Junction's policy to return *any child under 3rd grade* to school when someone is not able to meet the child at the bus stop. This is for your child's safety.

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TRANSITIONAL KINDERGARTEN ACKNOWLEDGEMENT

In accordance with District Board Policy, I understand that my child is participating in the Transitional Kindergarten program and will be in Kindergarten the following school year. I understand that Transitional Kindergarten students who show proficiency/mastery of Kindergarten standards may be promoted directly to first grade if the teacher, school administrator, and parent all believe it to be in the child's best interest.

Student Name	Date
Parent/Guardian Printed Name	Date
Parent/Guardian Signature	Date
School Representative Signature	Date

Kindergarten Parents!

Kids need shots to start kindergarten and need a complete health check-up for school.

Get your child ready to learn and do his or her best!

Make an appointment for a check-up and have the doctor fill out the attached form.

Take the form back to school.

Money problems? You may qualify for a free exam. Talk to your doctor or call 225-5122. Your child is all set!

Questions? Need help finding a doctor? Shasta County Public Health, Child Health & Disability Prevention Program (CHDP) can help!

Call CHDP at 225-5122
Or 1-800-300-5122

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31 of his/her first year in public school. A California licensed dental professional operating within his scope of practice must perform the check-up and fill out Section 2 of this form. If your child had a dental check-up in the 12 months before he/she started school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Sex: □ Male □ Female
Parent/Guardian Name:	Child's race/ethnicity: □ White □ Black/African American □ Hispanic/Latino □ Asian □ Native American □ Multi-racial □ Other_____ □ Native Hawaiian/Pacific Islander □ Unknown		

Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)

IMPORTANT NOTE: Consider each box separately. Mark each box.

Assessment Date:	Caries Experience (Visible decay and/or fillings present) □ Yes □ No	Visible Decay Present: □ Yes □ No	Treatment Urgency: □ No obvious problem found □ Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) □ Urgent care needed (pain, infection, swelling or soft tissue lesions)

_____ _____ _____

Licensed Dental Professional Signature ***CA License Number*** ***Date***

Section 3: Waiver of Oral Health Assessment Requirement

To be filled out by parent or guardian asking to be excused from this requirement

Please excuse my child from the dental check-up because: (Check the box that best describes the reason)

□ I am unable to find a dental office that will take my child's dental insurance plan.
My child's dental insurance plan is:

□ Medi-Cal/Denti-Cal □ Healthy Families □ Healthy Kids □ Other _____ □ None

□ I cannot afford a dental check-up for my child.

□ I do not want my child to receive a dental check-up.

Optional: other reasons my child could not get a dental check-up: _____

If asking to be excused from this requirement: ▶ _____

Signature of parent or guardian ***Date***

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school.

Return this form to the school *no later than* May 31 of your child's first school year.
Original to be kept in child's school record.

State of California—Health and Human Services Agency

Department of Health Care Services
Child Health and Disability Prevention (CHDP) Program

REPORT OF HEALTH EXAMINATION FOR SCHOOL ENTRY

To protect the health of children, California law requires a health examination on school entry. Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

PART I TO BE FILLED OUT BY A PARENT OR GUARDIAN

CHILD'S NAME—Last	First	Middle	BIRTH DATE—Month/Day/Year

ADDRESS—Number, Street	City	ZIP code	SCHOOL

PART II TO BE FILLED OUT BY HEALTH EXAMINER

HEALTH EXAMINATION

NOTE: All tests and evaluations except the blood lead test must be done after the child is 4 years and 3 months of age.

REQUIRED TESTS/EVALUATIONS	DATE (mm/dd/yy)
Health History	___/___/___
Physical Examination	___/___/___
Dental Assessment	___/___/___
Nutritional Assessment	___/___/___
Developmental Assessment	___/___/___
Vision Screening	___/___/___
Audiometric (hearing) Screening	___/___/___
TB Risk Assessment and Test, if indicated	___/___/___
Blood Test (for anemia)	___/___/___
Urine Test	___/___/___
Blood Lead Test	___/___/___
Other	___/___/___

IMMUNIZATION RECORD

Note to Examiner: Please give the family a completed or updated yellow California Immunization Record.
Note to School: Please record immunization dates on the blue California School Immunization Record (PM 286).

VACCINE	DATE EACH DOSE WAS GIVEN				
	First	Second	Third	Fourth	Fifth
POLIO (OPV or IPV)					
DtaP/DTP/DT/Td (diphtheria, tetanus, and [acellular] pertussis) OR (tetanus and diphtheria only)					
MMR (measles, mumps, and rubella)					
HIB MENINGITIS (Haemophilus Influenzae B) (Required for child care/preschool only)					
HEPATITIS B					
VARICELLA (Chickenpox)					
OTHER (e.g., TB Test, if indicated)					
OTHER					

PART III ADDITIONAL INFORMATION FROM HEALTH EXAMINER *(optional)* *and* RELEASE OF HEALTH INFORMATION BY PARENT OR GUARDIAN

RESULTS AND RECOMMENDATIONS

Fill out if patient or guardian has signed the release of health information.

☐ Examination shows no condition of concern to school program activities.

☐ Conditions found in the examination or after further evaluation that are of importance to schooling or physical activity are: *(please explain)*

I give permission for the health examiner to share the additional information about the health check-up with the school as explained in Part III.

☐ Please check this box if you ***do not*** want the health examiner to fill out Part III.

Signature of parent or guardian _____ Date _____

Name, address, and telephone number of health examiner

Signature of health examiner _____ Date _____

If your child is unable to get the school health check-up, call the Child Health and Disability Prevention (CHDP) Program in your local health department. If you do not want your child to have a health check-up, you may sign the waiver form (PM 171 B) found at your child's school.

CHDP website: www.dhcs.ca.gov/services/chdp

State of California—Health and Human Services Agency

Department of Health Care Services
Child Health and Disability Prevention (CHDP) Program

WAIVER OF HEALTH EXAMINATION FOR SCHOOL ENTRY

CHILD'S NAME—Last	First	Middle	DATE OF BIRTH—Month/Day/Year

ADDRESS—Number, Street	City	ZIP Code	SCHOOL	Teacher

PARENT OR GUARDIAN:

Please fill out this form if you want to excuse your child from the health examination required by California law for school entry. ***SIGN AND RETURN THIS FORM TO THE SCHOOL*** where it will be maintained as confidential information.

NOTE: SIGNING THIS WAIVER ***DOES NOT*** EXCUSE YOUR CHILD FROM RECEIVING THE IMMUNIZATIONS REQUIRED BY CALIFORNIA LAW FOR CHILDREN IN SCHOOL. ALSO, SIGNING THIS WAIVER WILL NOT DENY YOUR CHILD THE VISION AND HEARING TESTS DONE BY THE SCHOOL.

I have been informed about the health examination recommended by health professionals and required by state law. I have been informed about where my child can receive a health examination and about the income levels for receiving it at no cost to me.

Please check one of the following:

☐ I choose not to have my child receive a health examination as part of the school entry requirement.

☐ I would like my child to receive a health examination, but I am unable to obtain it.

Reason (see Health and Safety Code, Section 124085): _____

_____

_____ _____

Signature of parent or guardian — Date

INQUIRE AT THE SCHOOL OFFICE OR YOUR LOCAL HEALTH DEPARTMENT IF YOU WANT MORE INFORMATION.
CHDP website: www.dhcs.ca.gov/services/chdp

PARENTS' GUIDE TO IMMUNIZATIONS
REQUIRED FOR SCHOOL ENTRY

CDPH

Starting July 1, 2019

Students Admitted at TK/K-12 Need:

- **Diphtheria, Tetanus, and Pertussis (DTaP, DTP, Tdap, or Td) — 5 doses**
  (4 doses OK if one was given on or after 4th birthday.
  3 doses OK if one was given on or after 7th birthday.)
  For 7th-12th graders, at least 1 dose of pertussis-containing vaccine is required on or after 7th birthday.
- **Polio (OPV or IPV) — 4 doses**
  (3 doses OK if one was given on or after 4th birthday)
- **Hepatitis B — 3 doses**
  (Not required for 7th grade entry)
- **Measles, Mumps, and Rubella (MMR) — 2 doses**
  (Both given on or after 1st birthday)
- **Varicella (Chickenpox) — 2 doses**

These immunization requirements apply to new admissions and transfers for all grades, including transitional kindergarten.

Students Starting 7th Grade Need:

- **Tetanus, Diphtheria, Pertussis (Tdap) —1 dose**
  (Whooping cough booster usually given at 11 years and up)
- **Varicella (Chickenpox) — 2 doses**
  (Usually given at ages 12 months and 4-6 years)

In addition, the TK/K-12 immunization requirements apply to 7th graders who:

- previously had a valid personal beliefs exemption filed before 2016 upon entry between TK/Kindergarten and 6th grade
- are new admissions

Records:

California schools are required to check immunization records for all new student admissions at TK/Kindergarten through 12th grade and all students advancing to 7th grade before entry. Parents must show their child's Immunization Record as proof of immunization.